Report to the Legislature
from the
Advisory Council on Health Systems Development

Health Care Cost Drivers in Maine

Report and Recommendations

April 2009

DirigoHealth
Working For Maine

SUMMARY

The U.S. spends far more on health care than other developed nations yet our quality of care and outcomes are no better and we fail to cover everyone. The Advisory Council on Health Systems Development learned from a presentation by McKinsey Global Institute that a number of supply and demand issues fuel higher costs in the U.S.

Maine's cost crisis mirrors the national crisis. The Council's research reveals high per capita health care spending here largely due, not to an older or sicker population, but to how we use care and how much care we use.

From quality improvement experts we know that "every process is perfectly designed to get the results it gets". So what are the elements of health care delivery and payment that lead to high costs?

Transparency initiatives are telling us more about hospitals and insurance companies. MHDO's all payer claims system provides a rich resource to track spending and will soon provide comparative price information.

From Dirigo's Maine Quality Forum and others we are learning more about quality. For years we have known there is considerable variation in how care is delivered and in the cost of service across the state. That variation is enforced by a payment system with misaligned incentives that reward sickness rather than health, and care that is uncoordinated and duplicative – rather than collaborative, efficient, and effective.

The Public Purchasers' Steering Committee Annual Report showed the Council that changing payment incentives can change behavior and the results the system gets. The State Employee Health Plan created incentives (lower co-pays) to encourage members to use high quality providers. As members took advantage of these incentives, providers not on the list improved to qualify. The health plan now seeks data on efficiency to incentivize both high quality and low cost.

To gain better tools to measure cost and improve the efficiency of Maine's health care system, the Council examined two studies. Health Dialog Analytics, commissioned by Dirigo's Maine Quality Forum, revealed significant unwarranted variation that, if reduced, could save up to $300 - 400 million each year. A second study of hospital emergency department use, by the Muskie School, shows Maine uses 30% more emergency services than the national average. Health Dialog found an additional $115 million annual savings by reducing avoidable emergency department use. These savings could be used to reward more efficient and effective delivery and to lower premiums.

'How can these savings be realized?' is the charge to the Council. McKinsey tells us, "The efforts of decision-makers in all segments of U.S. health care system to address rising costs over the past two decades have had little effect."

New strategies are required in order to create a system of health care that delivers efficient, effective care. The Council recommends these incremental steps to re-align incentives and move to achieve that goal.

RECOMMENDATIONS

1. **Enact legislation to formally establish the public health infrastructure that has emerged under the State Health Plan as a prevention strategy for universal wellness, and use the new infrastructure as a base to invest Prevention and Wellness funds from the American Recovery and Reinvestment Act.**
2. **Support an interconnected electronic medical record system in Maine through HealthInfoNet.**
3. **Develop efficiency measures that can be used to offer incentives for patients to choose efficient, high quality providers.**
4. **Support fundamental payment reform to bring about a more efficient system of heath care delivery, beginning with a Patient Centered Medical Home pilot.**
5. **Identify and implement strategies to reduce Emergency Department use.**
6. **Develop an outreach strategy to disseminate findings from this study to the public.**

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BACKGROUND

The United States spends twice what other developed nations spend on health care yet we do not cover everyone and do not get better health or quality of care. In 2003 Governor Baldacci proposed and the Legislature enacted Dirigo Health Reform, a series of reforms to address health care cost, quality, and access including:

- Increased transparency about health care cost and quality.
- The Capital Investment Fund, a limit on new capital spending that assures that Mainers can financially support the added costs of those new investments.
- Creation of the Maine Quality Forum in the Dirigo Health Agency
- Reducing the hidden tax of bad debt and charity care by covering the un- and under-insured.
- A biennial State Health Plan, to improve the efficiency and effectiveness of Maine's healthcare delivery system and improve the health of Maine's people
- The Advisory Council on Health Systems Development (ACHSD) – a 19-member stakeholder advisory group that includes five legislators – which meets monthly and advises the Governor's Office in the writing and implementation of the State Health Plan and is responsible for an annual cost driver study and recommendations to the Legislature.

Maine is making progress implementing these reforms. While still too high, the growth in premium costs has moderated. From 2001 through 2006, Maine went from having the highest average annual growth in premiums in New England to the lowest. The United Health Foundation ranked Maine 19th in 2003 in covering the uninsured. By 2008, we ranked 5th. But costs are still too high and more clearly needs to be done. [i,ii]

In 2007, the Legislature required the ACSHD to report on cost drivers and recommend how to reduce spending without compromising quality or access. This report provides those findings, along with recommendations to reduce Maine's heath care spending. It reflects input received from stakeholders, including review and public comment of a draft of this document at the ACHSD's March 27 meeting.

The ACHSD also recognizes the excellent work under way around the state by a wide and diverse group of stakeholders – providers, consumers, employers, insurers and others – to reduce costs and improve quality. This document takes a next step, focusing on specific cost drivers and recommendations to build on that foundation.

TRANSPARENCY

The first step in Maine's effort to control costs is to better understand them through greater transparency about the costs and quality of our health care. Accordingly these transparency measures are now law:

Insurance companies annually report information to the Bureau of Insurance (BOI) on a standardized form so that consumers can see where our premiums go, and BOI posts summaries of this information at its website. The figures below, for instance, show the percent of premium that each insurance company pays for medical claims. Statewide in 2007, 84% of premium was spent on claims, while 9% went to administration and 7% was kept as profit. By contrast, 95.8% of MaineCare spending goes to claims, while 4.2% goes to administration.[iii]

Dollar Amount Spent on Claims and % of Premium 2007								
	Large Group		Small Group		Individual		Total	
	Prem %	Claims	Prem %	Claims	Prem %	Claims	Prem %	Claims
Aetna (Aetna Health Inc + Aetna Life	80%	$108,453,706	80%	$81,291,086	231%	$242,192	80%	$189,986,984
Anthem Health Plans of ME Inc	87%	$532,649,829	79%	$223,493,550	88%	$95,656,592	85%	$851,799,971
CIGNA (Cigna Healthcare of Me Inc +	84%	$106,219,635	0%	$0	149%	$115,944	84%	$106,335,579
Harvard Pilgrim Health Care Inc.	87%	$43,830,206	92%	$33,655,657	298%	$505,841	90%	$77,991,704
Mega Life & Health Ins Co	0%	$0	55%	$4,007,361	53%	$8,708,246	54%	$12,715,607
United Healthcare Ins Co	81%	$5,572,002	79%	$919,863	0%	$0	81%	$6,491,865
All other companies	80%	$4,677,554	103%	$1,762,301	65%	$2,898,343	78%	$9,338,198
Total	***85%***	***$801,402,932***	***80%***	***$345,129,818***	***83%***	***$108,127,158***	***84%***	***$1,254,659,908***

% of Premiums Paid and Representative Dollar Amount for Administrative Expenses: 2007								
	Large Group		Small Group		Individual		Total	
	Prem %	Claims	Prem %	Claims	Prem %	Claims	Prem %	Claims
Aetna	12%	$16,042,874	14%	$13,667,350	13%	$14,105	13%	$29,724,329
Anthem Health Plans of ME Inc.	4%	$25,015,875	11%	$32,035,552	11%	$12,292,280	7%	$69,343,707
CIGNA	9%	$11,516,714	0%	$0	8%	$6,165	9%	$11,522,879
Harvard Pilgrim Health Care Inc.	16%	$7,818,739	15%	$5,522,315	4%	$7,239	15%	$13,348,293
Mega Life & Health Insurance Co.	0%	$0	40%	$2,878,305	39%	$6,413,699	39%	$9,292,004
United Healthcare Insurance Co.	16%	$1,096,582	24%	$279,662	0%	$0	17%	$1,376,244
All other Companies	25%	$1,397,602	29%	$444,879	26%	$1,172,739	25%	$3,015,220
Total	***7%***	***$62,888,386***	***13%***	***$54,828,063***	***15%***	***$19,906,227***	***9%***	***$137,622,676***

Underwriting Gain/Loss: 2007								
	Large Group		Small Group		Individual		Total	
	Prem %	Claims	Prem %	Claims	Prem %	Claims	Prem %	Claims
Aetna	9%	$11,833,400	6%	$6,141,740	-68%	($71,784)	8%	$17,903,356
Anthem Health Plans of ME Inc.	9%	$57,667,352	9%	$26,621,055	1%	$577,695	8%	$84,866,102
CIGNA	7%	$9,247,739	0%	$0	57%	$44,466	7%	$9,292,205
Harvard Pilgrim Health Care Inc.	-3%	($1,407,455)	-7%	($2,456,087)	-202%	($343,459)	-5%	($4,207,001)
Mega Life & Health Insurance Co.	0%	$0	19%	$1,375,856	-1%	($163,634)	5%	$1,212,222
United Healthcare Insurance Co.	2%	$127,908	-4%	($47,676)	0%	$0	1%	$80,232
All other Companies	0%	($6,711)	-30%	($505,897)	19%	$838,720	3%	$326,112
Total	***8%***	***$77,462,233***	***7%***	***$31,128,992***	***1%***	***$882,004***	***7%***	***$109,473,229***

Source: Bureau of Insurance summary of Carriers Rule 945 filings, available at www.state.me.us/pfr/insurance.

Hospitals annually report their financial information on a standardized form to the Maine Health Data Organization (MHDO). MHDO posts summaries of this information at its website to help the public understand the financial condition of hospitals. For instance, the figure below shows one measure -- the number of days a hospital could continue to operate if it ceased to receive any more revenue.

Maine Health Data Organization
Hospital Financial Report Part I

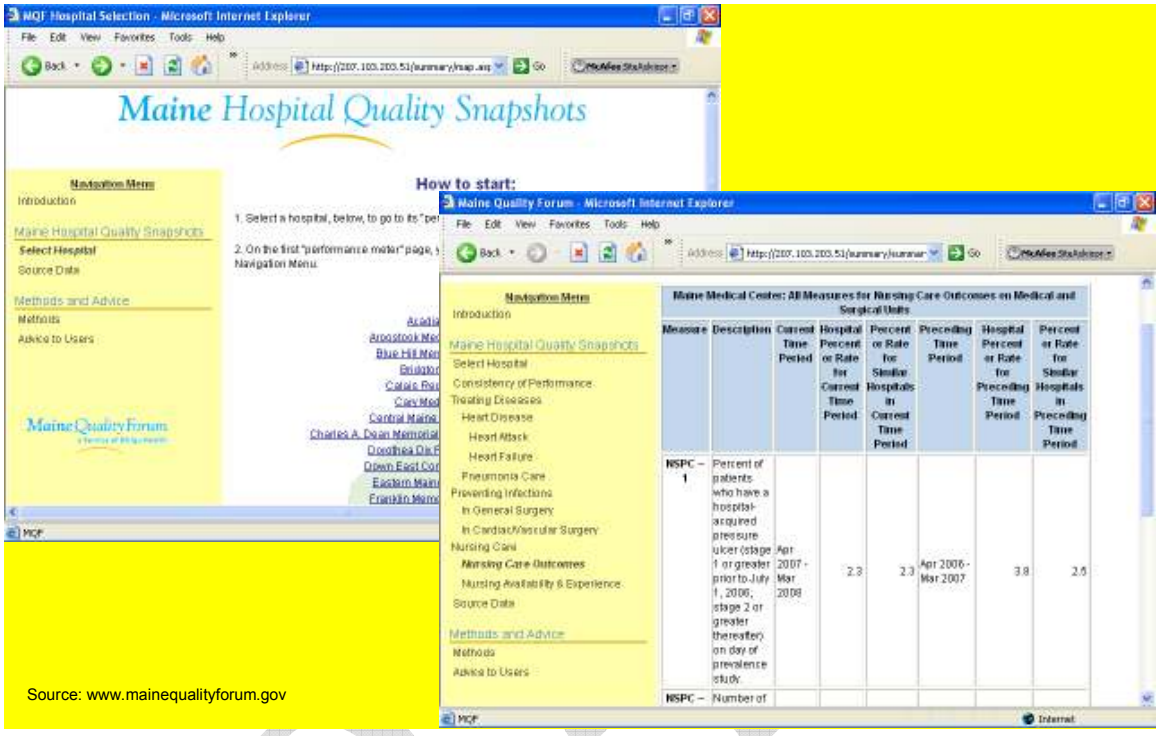
Days Cash on Hand (Inc. Board Designated & Undesignated Investments)

	FY 2005 Days	FY 2006 Days
Peer Group A Median -- 4 Hospitals	**116.0**	**116.2**
Central Maine Medical Center	28.2	34.5
Eastern Maine Medical Center	68.2	54.5
MaineGeneral Medical Center	163.7	177.9
Maine Medical Center	258.4	290.7
Peer Group B Median -- 8 Hospitals	**103.7**	**100.4**
Aroostook Medical Center, The (TAMC)	36.2	17.6
Mercy Hospital	81.0	247.7
Mid Coast Hospital	156.2	189.9
Penobscot Bay Medical Center	104.6	97.6
Southern Maine Medical Center	108.4	101.8
St Joseph Hospital	80.8	77.1
St Mary's Regional Medical Center	102.8	99.8
York Hospital	113.7	100.9
Peer Group C Median -- 4 Hospitals	**103.0**	**90.2**
Cary Medical Center	79.9	86.5
Franklin Memorial Hospital	126.2	94.0
Henrietta D. Goodall Hospital	272.8	184.0
Maine Coast Memorial Hospital	69.1	61.2
Peer Group D Median -- 5 Hospitals	**32.0**	**33.8**
Inland Hospital	54.0	63.1
Miles Memorial Hospital	15.9	33.8
Northern Maine Medical Center	32.0	33.4
Parkview Adventist Medical Center	2.3	2.5
Stephens Memorial Hospital	79.1	103.8
Peer Group E Median -- 15 Critical Access Hospitals	**67.4**	**60.8**
Blue Hill Memorial Hospital	97.5	201.7
Bridgton Hospital	41.7	45.6
Calais Regional Hospital	15.7	1.7
Charles A. Dean Memorial Hospital	26.7	25.5
Down East Community Hospital	65.8	50.3
Houlton Regional Hospital	49.8	41.7
Mayo Regional Hospital	108.8	103.5
Millinocket Regional Hospital	137.2	120.6
Mount Desert Island Hospital	67.4	69.8
Penobscot Valley Hospital	34.9	23.3
Redington-Fairview General Hospital	264.2	285.9
Rumford Community Hospital	43.2	35.8
St Andrews Hospital	113.4	101.9
Sebasticook Valley Hospital	91.2	60.8
Waldo County General Hospital	208.7	193.3

Source: www.healthweb.maine.gov

Price Posting. Hospitals and other providers are required to offer a price list showing the charges of commonly performed procedures. This provision will soon be replaced by an MHDO website where consumers can get comparative prices for health services.

Quality Data. The Dirigo Health Agency's Maine Quality Forum (MQF), posts provider quality data on its website. The web pages below, for example, show Maine Medical Center's performance on a range of measures.



COST DRIVER FINDINGS

Transparency measures provide a start, but we need to do more to understand and address health care spending.

The "ACHSD Data Book: Investigating Maine's Health Care Cost Drivers"[iv] (2007) provides background:

How Much Does Healthcare Cost in Maine?

- Premiums paid by employers in Maine are comparable to the rest of New England, but higher than overall US averages. That is because spending on actual medical services in New England is higher than elsewhere in the US.
- Maine has the second highest per person medical spending in the US – 24% higher than the US average – behind only Massachusetts.
    - While some of this is because Maine has an older population, most of the difference is not explained by age.

- Cost shifting from public payors does not explain Maine's high spending, since spending from all sources is counted in this calculation

What Drives Spending: Disease Burden, Inefficient Utilization, and Price

- Two thirds of health care spending is driven by how much we use, while one third is driven by the price of each service.
- ~~Poor health~~ Disease Burden is a major driver of utilization and therefore of spending.
  - Chronic illness, like diabetes, asthma, heart and lung diseases, account for about 30% percent of private premium costs as well as a significant share of MaineCare spending.
  - This means we can achieve savings by supporting efforts to make people healthier through evidence-based public health strategies, which will reduce preventable demand.
- Additionally, ~~but~~ much of the care provided to those with poor health does nothing to improve their health. That is, once people are sick, they are not treated as efficiently and effectively as possible.
  - National experts agree that roughly 1/3 of health care spending is on unnecessary or ineffective care.[v]
  - ~~We can achieve savings both by supporting public health efforts to make people healthier, and by finding and addressing areas where medical delivery system spending is inefficient.~~ There is considerable, unnecessary variation in how care is delivered across the state. The same person with the same illness is treated very differently.
  - Identifying places that use and spend less without sacrificing quality can provide models for efficiency.

Identifying the Inefficiency: The Variation Study[vi]

The Dirigo Health Agency's Maine Quality Forum contracted with Boston/Portland-based Health Dialog Analytic Solutions to perform variation analysis, looking at hospital, physician, clinical, and other professional services, which comprise nearly 2/3 of health care spending in Maine and nationally.[vii,viii]

The study – enabled by the recent completion of Maine's first-in-the-nation all payer claims database – provides a wealth of new information on specific areas of costs and possible saving. Claims data were made available for analysis by Health Dialog, under contract to the Dirigo Health Agency's Maine Quality Forum by the Maine Health Data Organization. Among the findings:

- There is significant variation across the 24 Healthcare Service Areas (HSAs) identified in the report (local health care markets, or areas where people generally go to the same providers for care).[ix]
- There is room for improvement across the entire state. While a few HSAs tend to be more efficient or less efficient for a range of health conditions, the majority of HSAs are in the middle, that is, they are more efficient when it comes to some conditions and less efficient when it comes to others.
- If we can reduce commercial payors' potentially avoidable inpatient use and high-cost/high variation outpatient use by 50% we could reduce commercial medical spending by 11.5%, which could reduce premiums as well.
- If we can reduce MaineCare's potentially avoidable inpatient use and high-cost/high variation outpatient use by 50% we could reduce MaineCare's medical spend by 5.7%. DHHS's contract with Schaller Anderson to improve the care of the costliest MaineCare members is designed to achieve such cost reductions.

Inpatient Findings

Potentially Avoidable Admissions

- Inpatient spending accounts for $916 million (39%) of the spending in Health Dialog's analysis, and about 1/3 ($284 million) of that amount – most of it spent on individuals with chronic conditions – is potentially avoidable.[x]
- Potentially avoidable admissions fall into two categories:
    - Ambulatory Care Sensitive admissions, which are admissions that could be avoided through better preventive care.
    - Admissions that are driven by factors other than illness prevalence, medical evidence, or patient preference. This is sometimes called "residual care" or "supply-sensitive care." The frequency of these admissions depends on local care characteristics or supply of services.

  Examples of potentially avoidable admissions include complications of diabetes, exacerbation of chronic pulmonary disease or congestive heart failure, and dehydration.
- The total statewide cost of potentially avoidable admissions to private payors is $83 mil, or 6.7% of total private health care spending (i.e., inpatient, outpatient, ED, and Rx).
- All HSAs have some potentially avoidable admissions, but some have more than others, from a low of about $250 to a high of about $600 in per person per year among the privately insured. Similar variation exists for other payors.
- This data is adjusted to make sure differences in age, sex, or illness so that we can make "apples to apples" comparisons between different regions.

Preference Sensitive Admissions

- "Preference Sensitive Care" accounts for $138 million (15%) of statewide inpatient spending
- "Preference Sensitive Care" is care for which (a) there is limited clinical evidence that one treatment option is better than another, and (b) the options carry significant tradeoffs in terms of risks and benefits for the patient. Examples include surgery or watchful waiting in early-stage prostate cancer; or surgery, angioplasty, or medication therapy for chronic, stable coronary heart disease.
- While the "right" decisions in Preference Sensitive Care would take patient preferences and values into account, studies suggest that it is more often the preference of the physician – rather than the patient – that drives the choice of treatment.
- Studies also show that fully informed patients generally choose less invasive (and therefore less expensive) treatments for these conditions.

~~"Preference Sensitive Care" accounts for about 9% of admissions statewide, but rates are higher among older populations. For instance 16% of private admissions among those aged 45-64 are preference sensitive.~~

Outpatient Findings

- Outpatient spending accounts for $1.3 billion (56%) of the spending in the analysis.
- Health Dialog identified five groupings of outpatient services that are high in both cost and variation and that account for nearly ¼ of all outpatient spending. Those services are: (1) lab tests, (2) advanced imaging (CT and MRI scans), (3) standard imaging, (4) echography (e.g., ultrasound imaging), and (5) specialist visits.
- The total, statewide cost of all high cost, high variation outpatient services to private payors is $200 million, or 16.2% of total private health care spending.
- All HSAs have some high cost, high variation outpatient use, but some have more than others, from a low of about $650 to a high of about $1100 in per person per year among the privately insured. Similar variation exists for other payors. This variation suggests overuse of some outpatient services which could be reduced without sacrificing quality.

Public Purchasers Steering Group (PPSG)

- The PPSG was created by the Dirigo Health Reform Act in 2003 to explore ways to coordinate to achieve health care cost savings. Members include the Maine State Employee Health Plan (SEHP), the Maine Municipal Association, the Maine Education Association, the University of Maine System, MaineCare, and the Dirigo Health Agency. Their health care spending totaled $2.9 billion in 2007, or approximately 30% of all health care spending in the state

- The PPSG reports that differing collective bargaining agreements among the various public employer groups have stood in the way of pooled purchasing. PPSG members participate in the Maine Health Management Coalition, a coalition of public and private employers statewide working on a range of initiatives to improve the health of their employees and to increase the value of their health care spending.
- The most recent PPSG report stated that "Outpatient hospital services continue to be the largest driver of cost (at 25.6 percent of total)."[xi]
- A primary interest on the part or the public purchasers is the development of "evidence based benefit design" to reduce use of services that do not deliver sufficient value.
- The SEHP uses benefits design to influence patient and provider behavior, and recently expanded its tiered hospital and Primary Care Provider network. Members who choose providers who meet certain quality metrics, have lower out-of-pocket costs.
- The SEHP's tiering plan has shown two promising results to date: (1) patients' choices have shown that consumers will respond to such incentives; and (2) despite the introduction of incrementally more challenging measures, Maine hospitals who were not on the preferred list have responded by improving their quality to be on the preferred list.
- The SEHP's Executive Director Frank Johnson told the ACHSD that the single biggest step forward that could be taken to reduce the SEHP's costs would be to do tiering based on efficiency (not just quality, as is the current practice), but that in order to do that, the SEHP needs publicly available data on provider efficiency.

Emergency Department Use Study

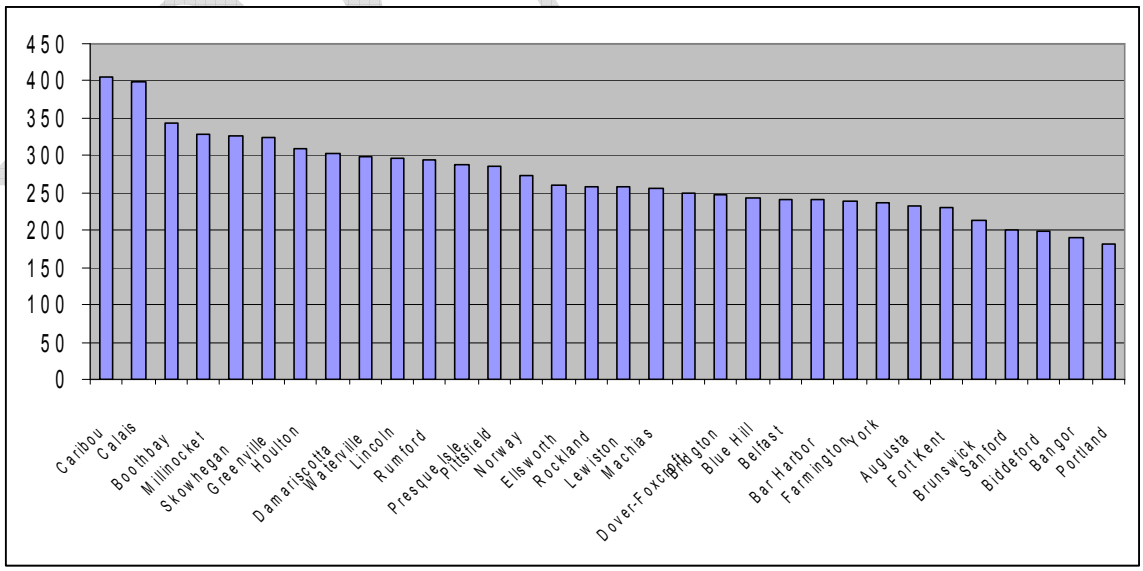
Last year, the Muskie School and the Maine Health Information Center conducted a study of ED-use across the state with funding from the Maine Health Access Foundation. Spending on ED services is not a major component of total health care spending, but high ED-use, especially when driven by conditions that can be treated in clinics or physicians offices, results in:

- ED overcrowding. This can endanger patients needing emergency care by leading to longer wait times, diversions to other EDs, etc.
- Added costs. ED treatment is more expensive than office-based treatment, due in part to the overhead costs associated with hospital care.[xii]
- Fragmented care. The ED is designed to provide immediate short-term care, not to be a source of care for patients with chronic conditions. And because EDs frequently do not have access to medical histories, prior test results, etc, ED-use for routine care can result in duplicative testing and other unnecessary spending.

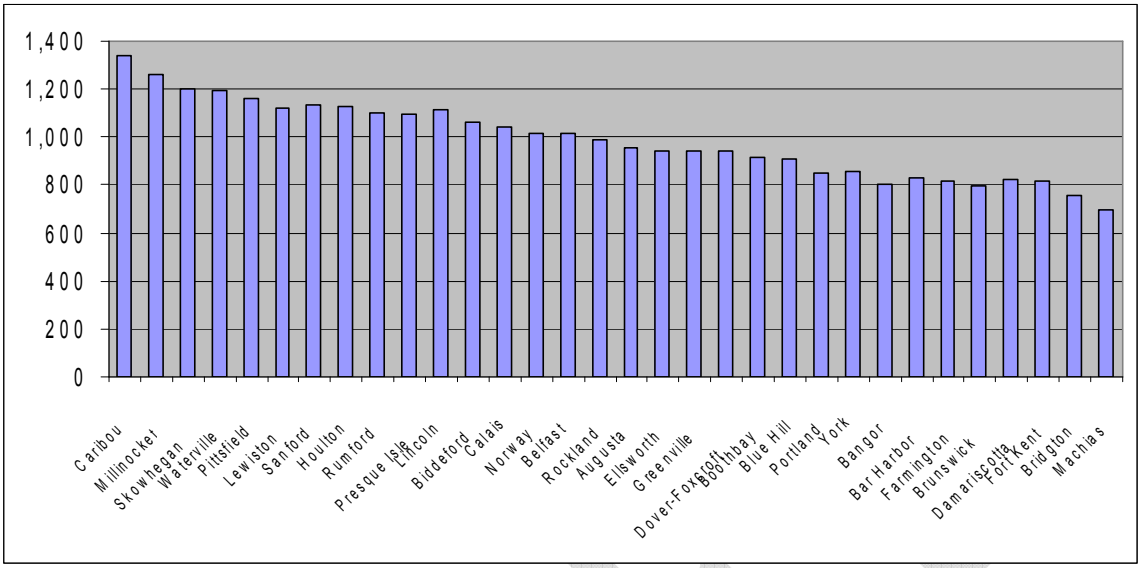
Among the ED-use Study findings:

- **Maine's emergency department use in 2006 was, in aggregate, about 30% higher than the national average.**
- **The uninsured are not a disproportionate driver of ED-use**: the uninsured accounted for 9% of outpatient ED visits, which is less than their proportion of Maine's population.
- **MaineCare patients accounted for 17% of the statewide population and 32% of outpatient ED visits**, while the privately insured accounted for 56% of the statewide population and 33% of outpatient ED visits, and MaineCare ED-use was 3.2 times higher than private use.[xiii] This data, however, is from 2006, which pre-dates DHHS contract with Schaller Anderson, who provides care management services for the top 10% of adults and top 5% of children who constitute high-risk, high-utilization and/or high-cost members, including members who utilize a substantial amount of emergency room services; ED-use among targeted members was reduced 1.8% over a two year period.
- **Some HSAs are consistent outliers, providing opportunity for action.** While MaineCare ED-use is higher than private use, HSAs with the high MaineCare ED-use also tended to have high private ED-use (see figures below). This suggests that there are system issues within those HSAs that drive higher ED-use among both populations, and that private payors in addition to MaineCare could achieve savings by reducing ED-use in those HSAs.

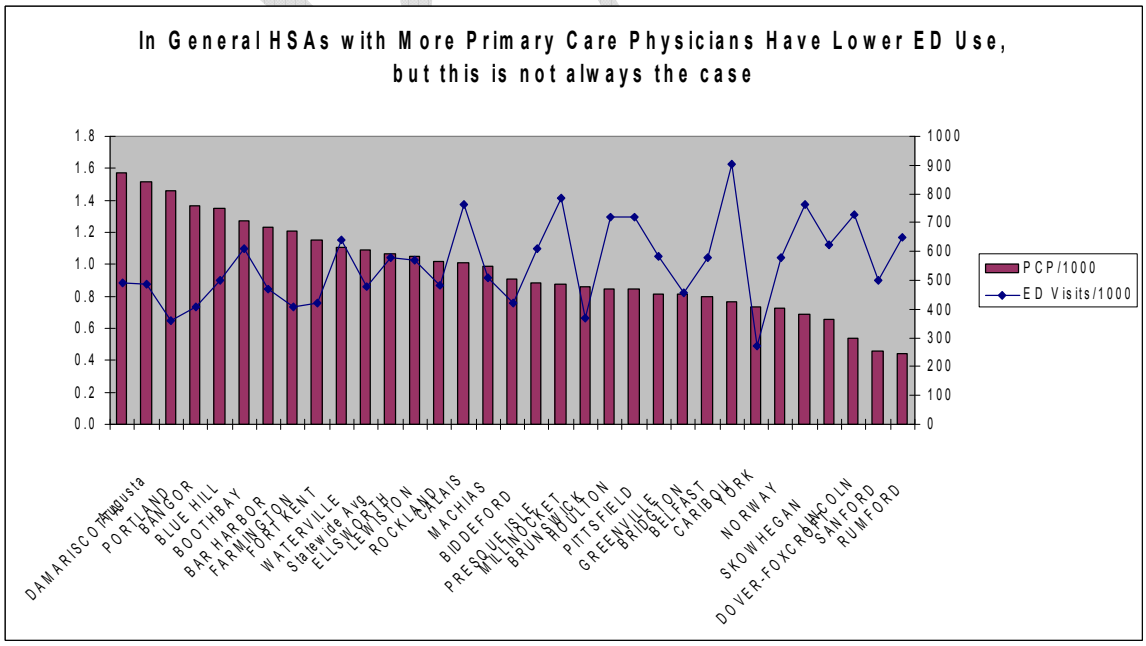
Age-Adjusted <u>Private Pay</u> Outpatient ED Visits per 1000 Members, 2006



Age-Adjusted MaineCare Outpatient ED Visits per 1000 Members, 2006



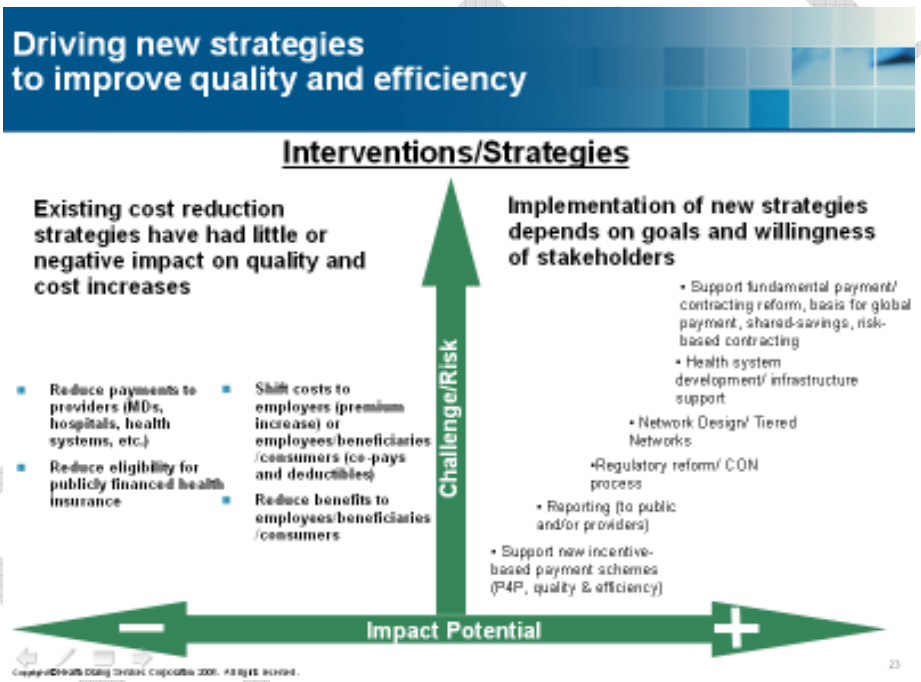
- **Primary care concentration is not the only factor that explains high or low ED-use in a community** (see figure below). While urban areas have more health care providers (which may be one of the causes of lower ED-use in these areas), the fact that several rural communities have low ED-use suggests that physician concentration is not the only factor that explains high or low ED-use in a community. Other factors might include: non-availability of urgent or primary care outside of school and work hours; lack of availability of telephone consultation; etc.



- **Approximately 75% of Maine's ED-use is avoidable, with costs of up to $115 million.**[xiv] Avoidable ED visits include ambulatory medical conditions that could probably be treated in a routine office visit, like headache, sore throats, etc. Unavoidable are more related to trauma, poisoning, etc.

RECOMMENDATIONS

New strategies are needed to reduce cost and improve quality, as noted in the chart below. This report provides priority recommendations of both short term and long term strategies to reign in cost growth. The Council recognizes that reducing health care costs is a journey, not a destination and will continue to analyze data, review with stakeholders, and make additional recommendations to the Legislature throughout the year.



Recommendation #1. Enact legislation to formally establish the public health infrastructure that has emerged under the State Health Plan as a prevention strategy for universal wellness, and use the new infrastructure as a base to invest Prevention and Wellness funds from the American Recovery and Reinvestment Act.

An essential strategy to contain health care costs must be to prevent disease from occurring. Public policy must support efforts to promote the conditions necessary for sustaining and improving health and eliminating racial, ethnic and socio-economic health disparities. Health care coverage and access to services is necessary but not sufficient to

improve health status. Decades of research have fully established the social as well as behavioral determinants of health.

Population based interventions like seat belts, air bags, drinking and driving laws, tobacco taxes, immunization requirements, and laws protecting indoor and outdoor air have a profound impact on the health of the population. Support for these efforts must be seen as part of our cost containment strategy.

Introducinge legislation to formalize Maine's public health infrastructure will have a significant impact towards these ends., ~~and charge it with the~~ It will establish a prevention strategy of Universal Wellness to help every Mainer know, understand and take action to reduce his or her risk for chronic illness. A report card should be developed to measure progress over time. This initiative would be conducted with existing funds and lay the groundwork for new resources for Prevention and Wellness included in the Recovery Act. Maine CDC/DHHS, with the Statewide and District Coordinating Councils and Maine's 28 Healthy Maine Partnerships, will lead the initiative. This system not only streamlines and coordinates a previously very fractured system, but also brings health care and public health stakeholders to the table at the local, district, and state levels for the purposes of improving the efficiencies and effectiveness in Maine's health system.

Recommendation #2. ~~Continue s~~Support ~~for~~ an interconnected electronic medical record system in Maine through HealthInfoNet.

Experts nationally agree that use of electronic medical records systems have significant potential to facilitate higher quality care and lower costs by bringing together patient-level electronic information and data which can be accessed and used by a variety of providers, making critical information available at the point of care and helping to avoid duplicative tests, procedures, and prescriptions.

Maine is ahead of the curve nationally in developing such a system. Work began in 2004, leading to the creation of HealthInfoNet an independent non profit organization in early 2006. With initial funding provided by the Maine Health Access Foundation and the Dirigo Health Agency's Maine Quality Forum, six provider organizations – including Maine's four largest delivery systems, an independent rural hospital and a multi-site primary care physician practice are participating – covering 40% of Maine's population agreed to a statewide demonstration that is projected to save $10.6 - $12.5 million annually. It is estimated that statewide full implementation of HIN will generate between $40 million and $52 million in annual savings.[xv] Maine CDC/DHHS has also been an early financial supporter of HealthInfoNet, and this has led to electronic submissions of hospital laboratory reports to Maine CDC's public health laboratory, improving efficiencies in the identification of outbreaks and other reportable diseases.

The Governor recently proposed using $1.7 million ~~in federal stimulus funding~~ made available by the American Recovery and Reinvestment Act to allow the demonstration to be completed, with funds be administered by DHHS to maximize any potential for Federal match. ~~That~~

Importantly, this funding ~~also~~ positions the state and HealthInfoNet to maximize dollars available in 2010 and later as part of the Recovery Act to support health information exchange.

Recommendation #3. Develop efficiency measures that can be used to offer incentives for patients to choose efficient, high quality providers.

The SEHP's experience showed that when patients have incentives to choose preferred providers, non-preferred providers respond by improving performance.

To help ~~the SEHP and other self-insured employers~~ encourage lower cost and high quality providers, MQF and Health Dialog should conduct a second phase of the claims analysis to examine provider-level costs and quality to provide the data that purchasers need to incentivize the use of efficient, high quality providers. This should be completed by spring 2010 and should be done transparently and collaboratively with providers, payers, purchasers, and consumers.

Recommendation #4. Support fundamental payment reform to bring about a more efficient system of heath care delivery, beginning with a Patient Centered Medical Home pilot.

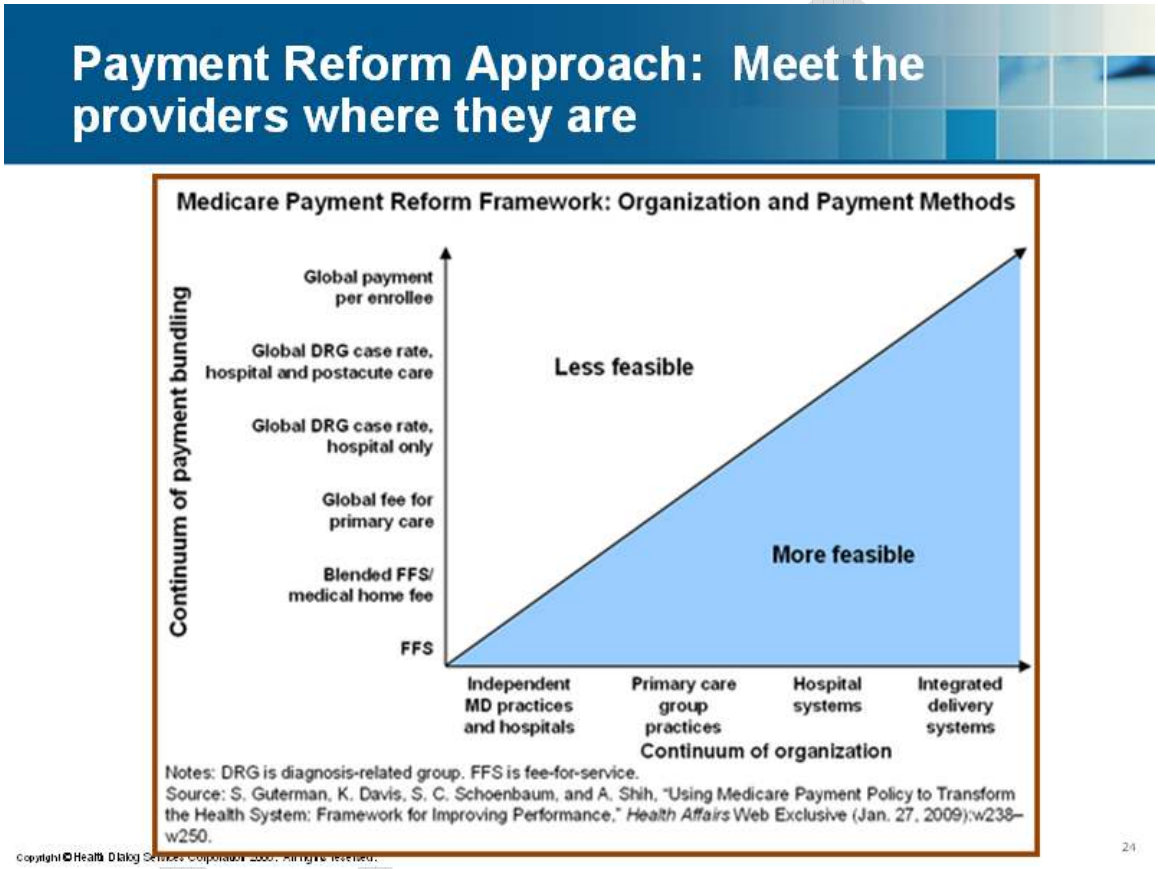
Work by McKinsey Global, the Commonwealth Fund, Health Dialog, and other experts nationally all conclude that the US's current payment system creates incentives for volume rather than outcomes, which results in inefficient delivery systems that provide uncoordinated and inefficient care.[xvi]

Thus, meaningful long term health care reform ~~will almost certainly~~ should include payment reform. Purchasers will look for ways to pay for health and healthy outcomes, rather than for the series of tasks associated with treating episodes of disease; reimbursement systems that provide incentives for providers to coordinate patient care and use evidence-based practices will facilitate more efficient delivery systems and eliminate inappropriate variations in care.

Where health care systems exist in Maine, payers and systems should work together to implement payment reform pilots. Where formal systems do not yet exist, MQF's continued analysis of Maine's all-payer claims database can identify areas where hospitals and primary and specialty care physicians work as an *informal* system~~, and this~~

~~analysis should be used to inform discussions on payment reform pilots to efficiently and effectively coordinate care between these providers~~.

As seen in the figure below from the Commonwealth Fund, formal, integrated care systems (such as the Mayo Clinic in Minnesota, Kaiser Permanente in California, and Geisinger Health System in Pennsylvania, all of which are known for efficient, high-quality care) are able to accept global payments for all the care of their patient populations because all the care is provided by members of the same organization.



However, Commonwealth's figure also shows that it is also possible to implement less sweeping payment reforms that "meet the providers where they are" now and provide incentives that will over time lead to more efficient delivery systems.

~~Recommendation #___. Continue support for the Patient Centered Medical Home pilot.~~

~~Potentially avoidable complications of chronic disease are responsible for large numbers of hospital admissions. A strong primary care system is important for adequate management of chronic diseases.~~

The need for a strong primary care system – particularly to prevent and manage chronic illness – provides a place to start.

The ~~PCMH~~ Patient Centered Medical Home model ~~offers a basis for change, with~~ provides that patients are cared for by effective, collaborative teams under a reimbursement model that supports coordinated, multidisciplinary care.

A pilot project to demonstrate the potential of this care model to improve care and lower costs is currently under way, with sponsorship from the Dirigo Health Agency's Maine Quality Forum, the Maine Health Management Coalition, and Quality Counts.

Multi-payor involvement is essential to the pilot's success. Accordingly, MaineCare and the state's four major private insurers – Anthem, Cigna Aetna, and Harvard Pilgrim – are all participating, and the Governor has proposed $500,000 in matchable state funds to support MaineCare's participation in this pilot.

MQF will report on the pilot's progress in January 2010.

Recommendation #5. Identify and implement strategies to ~~R~~reduce Emergency Department use.
~~**through the following:**~~
~~The Muskie School should c~~Conduct a Phase 2 ED study to perform an in-depth analysis of six HSAs representing high use and low use areas, as well as rural and urban, and geographic proximity and diversity, ~~so that we can~~ to better understand and address what drives high and low ED-use and develop interventions accordingly.

Recommendation #6. Develop an outreach strategy to disseminate findings from this study to the public.

Consumers have a critical role in reducing inefficiencies and ineffectiveness in the health care system. The first step for consumer engagement is education. The ACHSD and GOHPF will develop by May 1 an outreach plan to be sure the public and policymakers know, understand, and act on the information in this report. This education strategy will be ongoing as the ACHSD gathers new information and develops new recommendations.

~~**Recommendation #2. Modify Maine law to allow small businesses and other fully insured businesses to offer incentives.**~~

~~Current state law (specifically, 24-A MRSA 4303 and Bureau of Insurance Rule 850) create some barriers for fully-insured employers who wish to provide incentives to use efficient providers.~~

The SEHP's experience shows that, when patients have incentives to choose preferred providers, non-preferred providers respond by improving performance.

This recommendation allows all employers to offer tiering based on quality and efficiency once metrics are available

Recommendation #3. Mandate that payers and purchasers in Maine support informed medical decision making as a benefit in health insurance plans in Maine.

Studies have shown that shared decision making for preference-sensitive care options often results in patients' choosing less invasive and less costly treatment options, and patient satisfaction is higher as well.[xvii] A portion of the cost of preference-sensitive care could be reduced with no reduction in quality if patients participated in formal shared decision making processes. It should be noted that this would be a new mandated benefit.

Recommendation #7. Use the Certificate of Need program to help achieve an efficient delivery system.

Certificate of Need (CON) is a regulatory program currently in effect in 36 states and the District of Columbia that reviews and either approves or denies certain types of projects undertaken by health care facilities. In Maine, CON review is required for the expansion of existing services or facilities that cost more than a certain amount, the establishment of new services, or substantial reductions in capacity of certain types of providers.

Historically, only about one-third of all capital investments made by hospitals in Maine (the type of provider most often impacted by CON requirements) fall under CON scrutiny, with the other two-thirds exempt from review.

CON recommendation #1: the ACHSD should elaborate on the State Health Plan's CON criteria to specify that higher priority will be given to projects that explicitly address variation issues in the applicant's HSA as shown in the Health Dialog report and high ED use shown in the ED report. Further, the Department should use the Health Dialog and ED reports in assessing CON applications in regards to the statutory requirements of 22 MRSA § 335. This should apply to review starting in January 2010.

CON recommendation #2: the legislature should (a) eliminate the exemption of replacement equipment from CON review, and (b) lower CON review thresholds. As mentioned above, Maine's CON program covers only 1/3 of all capital investment in the state. These legislative changes would allow the CON program to cover a greater share of capital investment so that the CON program can review the need for projects and their potential impact on costs before projects can proceed.

ED Recommendations

While Phase 2 will take time to conduct, there are a number of recommendations that could be acted on immediately:

Require insurers to do more with nurse screeners pre-ED.

Require EDs to have a list of available primary care physicians.

Require hospitals that employ primary care physicians to have practices open on nights, early morning and weekends (open access).

Encourage community-based hospital/physician collaborations to create regular walk-in clinic hours at least several evenings per week.

Expand use of school-based health centers.

If there are no clinics or primary care provider staying open 24-7, require the ED to connect via telemedicine to a 24-7 provider

When other interventions do not work or are not available, turn the ED into the medical home for patients who continue to use the ED by test piloting a model of a primary care/urgent care center sponsored by a hospital and on hospital grounds to serve as a substitute care center for patients who continue to use the ED.

Ask FQHCs to report annually on their open access policies.

Present relevant ED data to the each of the eight public health District Coordinating Committees – including making public which primary care doctors have high ED use – so that they can develop and promote strategies to prevent avoidable ED use.

Require EDs to educate the public about avoidable hospital use, for instance with public service messages on TVs in the ED waiting room.

Work with insurers and MaineCare to share any ED savings (from any enacted recommendations from above) with providers to help pay for any costs associated with those recommendations.

Recommendation #10: Increase transparency through the following:

The Bureau of Insurance should design a checklist of questions that consumers can use when purchasing plans on the individual market to help consumers understand what are purchasing; e.g. what is the deductible and what is included and excluded from it; what is the a lifetime benefit limit; do deductibles and benefit limits apply to the family as a whole or to each family member separately; etc.

The Bureau of Insurance should develop a standardized explanation of benefits form to help consumers understand who provided the service(s), when, where, how much was charged, how much of the charge was paid, how much is the consumer's obligation, and why a service was not covered.

To provide greater transparency to the public about what drives premium increases, the Bureau of Insurance should produce and post a summary of each insurance company's 945 filing to translate findings to the public.

APPENDIX

The Department should use the Variation and ED reports in assessing CON applications in regard to the following statutory requirements of 22 MRSA § 335:

Subsection 1: "the commissioner shall approve an application for a certificate of need if the commissioner determines that the project…B. Is consistent with and furthers the goals of the State Health Plan…[and]… D. Does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum,"

Subsection 7: " the commissioner shall issue a certificate of need if the commissioner determines and makes specific written findings regarding that determination that…D. The proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by: (1) The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care."

[i] According to the federal Medical Expenditure Panel Survey, Maine's average annual increase from 2001 to 2003 was 13.2% versus an average of 10.1% of the other New England states, while from 2004 to 2006 it was an average of 6.4% versus 8.1% of the other New England states.

[ii] www.americashealthrankings.org/2008/pdfs/me.pdf

[iii] Includes portion of OIAS expense allocable to MaineCare.

[iv] Available at www.maine.gov/gohpf.

[v] www.rand.org/pubs/research_briefs/RB4522/index1.html, www.rand.org/health/abstracts/project_descriptions/Compare.pdf

[vi] Summary of methodology: Commercial, Medicare, and MaineCare claims were sorted by Healthcare Service Area (HSA) and analyzed to discover what services were responsible for large amounts of spending. Costs were separated into inpatient and outpatient categories. Inpatient costs were divided into necessary and potentially avoidable costs. (Potentially avoidable services are those which could be avoided with better outpatient care or those for which there is large local variation in use which is not explained by medical evidence, local disease incidence, or patient preference.) Outpatient costs that were high and highly variable were examined.

[vii] **According to the most recent state estimates from the federal government health care spending in Maine was $8.6 billion in 2004.** This is medical service spending only, and therefore does not include the portion of premium that goes to profit or administration. If Maine spending since 2004 has increased as the same rate as historical and projected national spending, Maine spending would total $11.6 billion in 2009.

[viii] **The other categories of health care spending in the federal government's estimates are:** Drugs and Other Medical Nondurables (12%); Dental Services (4%); Home Health Care (2%); Durable Medical Products (1%); Nursing Home Care (7%); and Other Personal Health Care (10%; this category includes (1)

in-plant services provided by employers for the health care needs of their employees, (2) publicly funded expenditures for medical care delivered in non-traditional medical provider sites, such as senior citizen centers and schools, and it includes Home and Community-Based Waivers under the Medicaid program (which allow states to provide care that otherwise require long-term inpatient care in a hospital or nursing home in other settings (e.g., PNMIs)).

[ix] Maine has 36 Healthcare Service Areas. In this analysis, some were combined to yield larger – and therefore more statistically relevant – numbers for analysis.

[x] The top 3 types of potentially avoidable admissions (Respiratory, Cardiac and Gastrointestinal) make up 51% of all PA admissions ($146 mil).

[xi] "Outpatient hospital services" includes diagnostic and lab services, medical and surgical procedures, and professional fees billed by the hospital. "Total" includes hospital inpatient and outpatient, professional, ancillary and prescription drug expenses.

[xii] One Maine study (Maine Health Information Center. 2007. Emergency Department Use Among State of Maine Employees) found that for six diagnoses frequently seen in EDs but usually treated in office settings (strep throat, conjunctivitis, external and middle ear infections, upper respiratory infections, bronchitis, and asthma), the average cost in the ED was more than five times the average cost for office based care for these same conditions.

[xiii] 918 outpatient ED visits per 1000 MaineCare members versus 284 per 1000 privately insured members.

[xiv] Savings estimate from Health Dialog -- rather than USM -- analysis. Avoidable includes ambulatory medical conditions that could probably be treated in a routine office visit, like headache, sore throats, etc. Unavoidable are more related to trauma, poisoning.

[xv] "The Impact of Electronic Health Information Exchange (HIE) Services in Maine: Avoidable Service and Productivity Savings Estimates Related to HealthInfoNet Services." Shaun T. Alfreds, MBA & David M. Witter, Jr., MA. Prepared for The Maine HealthInfoNet Stakeholder Group, Maine Quality Forum. Project Support Provided by HealthInfoNet. November 2008

[xvi] See, for example, McKinsey Global Institute "Accounting for the Cost of US Health Care - A New Look at Why Americans Spend More," December 2008; and Commonwealth Fund Commission on a High Performance Health System "The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way," February 2009.

[xvii] Morgan et al, J Gen Int Med 2000, 15:685-93., Kennedy et al, JAMA 2002, 288:2701-2708.